IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF OKLAHOMA

EQULLA M. BROTHERS, as the Personal Representative and Administratix of the Estate of Daryl Clinton, Deceased,

Plaintiff,

-vs-

(1) TOMMIE JOHNSON III, in his official capacity as Oklahoma County Sheriff,

Defendant.

No. 5:2021-cv-418

CERTIFIED COPY

30(b)(6) DEPOSITION OF TOMMIE JOHNSON, III, OKLAHOMA COUNTY SHERIFF, THROUGH ERNEST EUGENE "GENE" BRADLEY

TAKEN ON BEHALF OF THE PLAINTIFF

IN OKLAHOMA CITY, OKLAHOMA

ON FEBRUARY 28, 2023

COMMENCING AT 9:08 A.M.

INSTASCRIPT, LLC
125 PARK AVENUE, LL
OKLAHOMA CITY, OKLAHOMA 73102
(405) 605-6880
www.instascript.net

REPORTED BY: LORI JOHNSTON HARSTAD, CSR

APPEARANCES

FOR THE PLAINTIFF:

Geoffrey Tabor
Meagan Crockett-Edsall
Attorneys at Law
Ward & Glass, LLP
1601 36th Avenue NW
Suite 100
Norman, OK 73072
geoffrey@wardglasslaw.com
Meagan@wardglasslaw.com
-and-
Beau Ann Williams
Attorney at Law
Beau Williams Law Firm
4901 Richmond Square
Suite 104
Oklahoma City, OK 73118
Beauwilliamsatty@gmail.com

FOR THE DEFENDANTS TOMMIE JOHNSON, III, in his official capacity as Oklahoma County Sheriff:

Rodney J. Heggy
Assistant District Attorney
Office of the District Attorney-Oklahoma County
320 Robert S. Kerr
Suite 505
Oklahoma City, OK 73102
Rod.heggy@oklahomacounty.org

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STIPULATIONS

It is hereby stipulated and agreed by and between the parties hereto, through their respective attorneys, that the deposition of the Oklahoma County Sheriff's Office through Ernest Eugene Bradley may be taken on behalf of the Plaintiff on February 28, 2023, in Oklahoma City, Oklahoma, by Lori Johnston Harstad, Certified Shorthand Reporter within and for the State of Oklahoma, pursuant to notice and agreement.

It is further stipulated and agreed by and between the parties hereto, through their respective attorneys, that all objections, except as to the form of the question or the responsiveness of the answer, are reserved until the time of trial, at which time they may be made with the same force and effect as if made at the time of the taking of this deposition.

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ERNEST EUGENE "GENE" BRADLEY,

Of lawful age, having been first duly sworn, deposes and says in reply to the questions propounded as follows:

DIRECT EXAMINATION

BY MR. TABOR:

Q Sir, would you state your full name for the record, please.

A Yes. It's Ernest Eugene Bradley.

Q And are you suffering from any medical condition or have you taken any medication that would prevent you from giving clear, honest testimony today?

A No.

Q Have you given deposition before?

A Yes. One.

Q Okay. And just very generally, what were the circumstances of that deposition?

A It was so long ago, I believe -- I believe it was an inmate death. I don't remember who the inmate was. It was pretty early on in my career. And then I ended up having to testify in that same case based on policies.

Q And I would take it, given your line of work, you have probably given a lot of courtroom testimony. Is that right?

A Unfortunately or fortunately, no. I have not. Yeah.

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Q That might be fortunately.

A I think so.

Q I think I agree with you on the "fortunately" part.

A I think so.

Q Well, I know you're well prepared. You've got good counsel, but I will just give you a quick refresh of the rules. I will try to be as brief as possible, and I will let you finish your answers. You let me finish my questions. You know, when we have a friendly conversation, we interrupt each other in a real casual way. A deposition, we've got to be very mechanical so we have a clean transcript with our court reporter, so there's no breaks in the record.

Remember, if you can, give clear "yes" or "no," or if it's a narrative answer, answer that way rather than an "uh-huh" or a nod of the head or something, because that's a little harder for our court reporter to transcribe that. We just want the record to be clear. And if you do do that, I will kind of remind you. I am not picking on you. I'm just making sure we've got a clear record. So I may say, "Is that a 'yes' or is that a 'no.'" It happens all the time. I would -- I would be the worst offender of that if I got deposed. So...

What is your current job title?

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A I am Lieutenant with the Oklahoma County Sheriff's Office. I am the mental health coordinator for the County Sheriff's Office.

Q Okay. And if you could -- I know I am going to give you a history quiz here. If you can kind of walk through your employment with me, kind of generally, let's say, with the County, with Oklahoma County. Kind of tell me your trajectory you've had.

A I started with the County Sheriff's Office in 2002. Worked the floors, was what was called a floor rover. 2003, I made corporal and was moved into the accreditation department. That was preparing the jail for ACA accreditation and then, eventually, NCCHC accreditation.

Did that. Oh, I made sergeant in 2005, same department. And then made lieutenant in 2006 and was -- same department but, in addition, was considered the administrative lieutenant. 2008, made captain. Went to the National Jail Leadership Academy at Sam Houston, the Jail Administrators Academy through the National Institute of Corrections, in preparation to kind of move into more of an administrative role as being a captain.

Was a captain from 2008 until 2020. The only change, really, was from 2018, under Sheriff P.D. Taylor, July 1st of 2018, to July 1st of 2020, I was considered the

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Assistant Jail Administrator.

Q And could you tell me that last time frame when you were considered the Assistant Jail Administrator?

A July 1st, 2018 to July 1st, 2020, when we gave up the jail to the Trust.

Q As I understand, like you said, July 1 of 2020 is when the operation of the jail was handed over to the Trust. Was the decision made to do that handover in 2019?

A The works were probably early on in 2019. Over -- over my tenure there, there was always kind of conversations about doing either a financial trust or something trying to appease some of the Department of Justice concerns and that kind of stuff. So I think the beginning of 2019, it really started pushing that way.

Q Tell me kind of, at least in your role here today, your understandings why those conversations started happening about a potential transfer.

A So DOJ had been involved with us since 2003. There were numerous standards that they wanted us to improve on. We were making vast improvement, but I think -- I think the county commissioners -- and this is my opinion. I think the county commissioners viewed a change to be something positive, a positive message to the Department of Justice, even though, from our last audit in 2019 with the Department of Justice, we were found in

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complete substantial compliance with all of the standards.

But I think the cart had already been put before the horse at that point, and they just were invested in that change of the administration and control over the jail.

Q I am going to -- and I apologize. I am going to be getting up and kind of walking around here today with our exhibits we have. I am going to be putting some of the exhibits for you, sir, here on our TV. If you need me to scroll, move anything around, blow it up, let me know. But I am -- got here marked as Exhibit 1 to your deposition the notice for today's deposition under Federal Rule 30(b)(6). Do you see that?

A Yes.

MR. HEGGY: No. That's not the right one, Counsel.

MR. TABOR: Oh, you're right, Rod. That's the original one. Huh?

MR. HEGGY: Well, that's the one to somebody else. To Turnkey.

MR. TABOR: Oh, gosh. I pulled the wrong one.

MR. HEGGY: Yeah. So pull up the one to the sheriff. Or I can go get it if you...

MR. TABOR: No. I will pull it. Sorry about that.

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MR. HEGGY: No worries.

MR. TABOR: We can go off the record real quick.

(Short Recess from 9:16 a.m. to 9:20 a.m.)

Q (By Mr. Tabor) So while that's coming up on the screen, sir.

A Uh-huh.

Q Are you -- is it your understanding you've been designated under Federal Rule 30(b)(6) to give testimony on behalf of the sheriff in his official capacity here today?

A Yes.

Q And have you reviewed the contents of the amended notice filed in this case for your testimony here today?

A Yes.

Q And are you prepared to give testimony on behalf of the sheriff here today?

A Yes.

Q Okay. Now I correctly have the notice for today's deposition, the amended notice. Now, as you know, sir, at no point today am I going to be asking you to tell me conversations you have had with the sheriff's counsel, Mr. Heggy, anyone.

So with that in mind, I would ask you, tell me everything you did to prepare for today's deposition.

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A Of course, read this document. There's a list of policies that were identified in this. I re-read those policies to refresh my memory on the policies. It's been three years, and I've got another set of policies, so just to refresh my memory on that. I have read the investigative report completed by Deputy Peek, and then the update on the Serious Incident Review.

Q And after reviewing all that information, you feel that you are competent to give testimony on behalf of the sheriff?

A Yes.

Q For the topics in the notice. Correct?

A Yes.

Q Okay. Now, you were mentioning some policies reviewed. As I understand, some of those have likely changed since the time for the policies that were applicable to our case here and after that. Correct?

A Correct.

Q Okay. Now, you mentioned you reviewed Peek's investigative report and then the update to the Serious Incident Review. Is that -- is that accurate?

A Yeah. It's the Serious Incident Review that was done, and I think it had -- it was the update because it had the ME's findings on it.

Q The ME findings as to Mr. Clinton's cause of death?

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A Yes.

Q Okay. I am introducing Exhibit 2A to your deposition. This is going to be the quality assurance policy that was produced in this case.

Could you tell me very generally the purpose of the quality assurance practices and policies of the Sheriff's Department?

A Yeah. So quality assurance is, obviously, a best practice that you do in lots of different things, but certainly corrections. So we had created a Quality Assurance Review Team that was responsible in obtaining documentation that would substantiate standards for ACA accreditation, standards for NCCHC accreditation, and standards for PREA accreditation. And then they also monitored any of the standards that DOJ had identified that were deficiency, or even in compliance, just to maintain that compliance.

Q Now, was there ever any type of quality assurance review undertaken regarding the death or care given to Mr. Clinton in August of 2019?

A There would have been a Serious Incident Review for the death and there would have been a Mortality and Morbidity Review, not necessarily a quality assurance review.

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Q So kind of tell me the differences, if any, between those three and when you might have one or two of those but not a third.

A Sure.

Q And kind of what happens there.

A Well, quality assurance --

MR. HEGGY: Object to the form. It was a compound question.

But go ahead. Do your best.

THE WITNESS: Quality assurance certainly would be making sure that documentation throughout the facility are substantiating standards that officers are doing what they're trained to do, that time frames are met, inspections are done, those kind of things. So it's more of a process of paperwork versus anything.

A Morbidity and Mortality Review, obviously, is going to be specific to a death. And that was completed by Turnkey and always would reflect if there was any policy failures, if there was things that needed to be changed by them. And then Serious Incident Review was by the investigators, basically, to do the same thing: To look at what had happened, all the facts in the case, and was there anything that needed to be changed/developed.

Q (By Mr. Tabor) And so the Serious Incident Review here came through the Peek investigation?

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A Correct.

Q And if there was a Morbidity and Mortality Review, that was processed through Turnkey?

A Correct.

Q Now, in your understanding of Morbidity and Mortality Review when Turnkey, or whatever medical entity is contracted at the time, does that review, does that review review any conduct of jail staff or is morbidity and mortality always limited to the medical contractor's side of things?

A I don't recall it ever reflecting conduct on security staff. That would have been more Serious Incident Review.

Q Okay. Now, are you familiar with -- well, let me get it pulled up here first. I am marking Exhibit 2B to your deposition. This is going to be the inmate classification policy.

A Uh-huh.

Q Tell me the general parameters of this policy.

A Sure. So this is a policy that outlines the classification process of all residents of the Oklahoma County Detention Center. It is a classification program called the "Objective Jail Classification Program," created by -- I believe the company is Northpointe. And it's sanctioned by the National Institute of Corrections.

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It is an objective jail classification system to take out staff's perceptions, per se, and do a point system for everybody that comes into the jail. So every inmate that is booked into the jail, upon intake, is gone through a classification based on their charges, their history, history of being in the jail previously, any disciplinary records previously, needs assessments, and just current -- current charges.

And that comes up with a point scale that allows the classification officer to place them either in minimum, medium, or maximum security based on those points.

Q Is part of this inmate classification policy taking into account the health of the inmate when being classified?

A Yes, it is.

Q And why is that?

A Because of the -- the special needs that an individual might have based on their health. If they are in a wheelchair, if they have to have a cane to walk, of course, they can't be placed in general population because of those. So that would be a factor that would weigh into their housing assignment.

Q And when doing inmate classification, why does the County review those types of health situations or conditions of an inmate?

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A Well, it's obviously to get needs met by the individual to -- the whole system is set up to protect the inmate, to protect other inmates, and to protect facility security. So if they're an escape risk, for instance, that's going to weigh a factor of where we place them based on those needs.

Q And in carrying out the inmate classification policies and practices, is detention staff involved in that?

A It's only detention staff.

Q Only detention staff.

So the County expects detention staff, and detention staff alone, to comply with this policy, 4105.04?

A Correct.

Q Okay. You mentioned, as an example earlier, a detainee or an inmate being in a wheelchair being a factor that the County would take into account in inmate classification. Correct?

A Correct.

Q Would paralysis of limbs be a factor that would be taken into account?

A Yes.

Q Would inability to walk be a factor that would be taken into account?

A Yes.

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Q Would inability to eat or drink be a factor?

A Yes.

Q Would a detainee's inability to urinate or defecate be a factor?

A Yes.

Q And would you agree that, under the classification policies we have been reviewing, this policy allows the jail staff to classify or reclassify a detainee as a high-risk detainee for a health emergency?

A Yes.

Q I am next going to introduce Exhibit 2C to your deposition. This is going to be the inmate housing plan policy. Sir, tell me about the general nature and aims of this policy.

A So this is -- this kind of goes with the classification policy. So once they're classified, then the inmate housing plan actually takes effect. It outlines all the different types of individuals that we will have in the detention center and how they need to be housed, males separate from females, juveniles separate from adults, medical, your minimum, your mediums, and your maximums, protective custody, and medical.

Q And the third paragraph on page 1 of this policy notes, in part, that the procedures for housing inmates, among other things, is intended for the safety of

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inmates and the detention center staff. Is that correct?

A That is correct.

Q Now, similar to my questions before, on this policy, 4115.01, is this intended to be used and carried out by solely the detention staff?

A Yes. The only caveat to that is 13 Baker. To place an individual into 13 Baker, medical needs to be approving that as well. So they play a role in that because that's the infirmary. To take somebody out of 13 Baker, same thing applies. Medical needs to be involved in that. So it's a joint decision for 13 Baker.

Q So that would be -- and so -- and I know what you're saying. Let's just have a clear record.

Tell me what 13 Baker is.

A 13 Baker is the infirmary, the medical infirmary. The entire 13th floor is medical, but 13 Baker would be considered the infirmary.

Q Okay.

A So lots of times, they want to -- just like an ICU at a hospital, they want to manage or be a part of managing that bed space.

Q So in implementing -- we're talking about the inmate housing plan policy. There is some involvement, as you're saying, by the medical staff for inmate transfers into 13 Baker and out of 13 Baker?

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A Correct.
Q That would be a situation where medical staff is involved in implementing inmate housing plan policy?
A Correct.
Q But in all other instances, the County expects detention staff, solely, to carry out the inmate housing plan policy. Correct?
A That's correct.
Q I am looking here on page 4 of Exhibit 2C on the inmate housing plan policy. We have got this bullet-pointed list at the end entitled, "Exceptions to Random Housing."
Do you see that, sir?
A I do.
Q Tell me -- well, I will start here. So the introductory bullet point says:
The following categories of inmates are exempt from random housing procedures due to potential for behavioral problems.
Tell me, what are "random housing procedures"?
A So the random housing is going to be the implementation of just the point system and the inmate classification system. Those that would exclude or could be overridden are the ones that are listed on the bullet point of being sentenced to death, special care, if they

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have to go into protective custody, administrative segregation.
So that's a -- that's a decision from administration because of behavioral problems or an at-risk inmate. And that could be either at risk for sexual standards that violates the PREA standards or at risk of being a victim of sexual assault. And those would all be overrides from the traditional housing matrix.
Q And these are overrides that jail staff, themselves, can carry out. Correct?
A Correct.
Q On that list, what is "special care" intended to cover? Could you give more specificity to that?
A "Special care" could be high risk, high profile. For instance, if you remember with the bombing here in Oklahoma City and we had that individual, he was special care. So he was overridden and had a specific place for him to be on 13. It could be even medical stuff in regards to severe psychiatric things, severe medical issues, those kind of things. And then that referral or that override would go to medical to see if they concur with that.
Q And I am now on Exhibit 2C, our inmate housing plan still, page 2 at the top. It notes that: "Housing assignments are based on classification criteria that will

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include, but will not be limited to," and one of the items listed here would be medical and/or mental health needs.
Do you see that?
A I do.
Q And so tell me why that is a topic that jail staff are expected to evaluate?
A Again, the -- the goal of inmate classification is to place the individual in the safest environment possible. So based on all the information they have, which could include medical issues, amputees, wheelchairs, all of those that we had talked about before, or severe mental health needs, that's going to play a role that they can't be placed in general population. They're going to have to be placed in special -- special area.
Q Okay. I am next going to introduce Exhibit 2D to your deposition. This is the sight check policy that was produced in this case.
Similar to before, could you walk me through the sight check policy in terms of its purpose?
A Sure. The sight check is basically a procedure to the detention staff on how to conduct an appropriate sight check of visual observation of the inmates and their housing area and how frequently -- based on their classification, how frequently that sight check needs to be completed.

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Q And the purpose and scope of the sight check policy, among other things, states that "Sight checks are established to ensure the safety and security of our inmate population."
Do you see that?
A Yes.
Q Now, given that evaluating safety and security is one of the purposes and scopes of the sight check policy, would you agree that, when someone's carrying out sight checks, that jail staff must pay attention to what they're observing regarding the inmate population?
A Yes.
Q Now, as part of a reasonable sight check that would comply with the sight check policy, would you expect a reasonable detention officer to pay attention to the appearance and behavior of an inmate?
A The policy outlines that -- and it's based off of the jail standards, is what they are looking for is flesh and movement. So as long as they're looking in that cell and they see the individual, they recognize that is the individual that belongs to that cell, and there's movement, that's a completed sight check.
Q So they do need to, I guess, first see the inmate. Correct?
A Right.

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Q And physically evaluate -- could you be a little more specific? I am not trying to be thick. When you say "flesh," what do you mean there?

A Lots of times inmates will cover themselves completely with a blanket, those kind of things. You can't trust, because you see a large mound laying on a bed, that that is an inmate and that they're moving and they're okay. So you have to see flesh, either face, arms. Lots of times, inmates will reach out and wave to you just because they're sleeping and they're like, "yeah, you did your sight check, move on" kind of thing.

And so that's flesh and movement, obviously, is knowing that they are alive.

Q Okay. Is a part of the sight check policy, in terms of looking for, one, flesh and, two, movement aimed at constantly reevaluating the health and safety of the inmate each time a sight check is performed?

A Health, safety, and security.

Q Okay. Now I am going to go to page 3 of the sight check policy. We're going to go to Roman numeral 4 about at-risk inmates.

Tell me who qualifies as an at-risk inmate under this section of the policy at IV.

A If I remember right, that actually refers to another policy called "At-risk Inmates." And so that is

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your high-profile individuals, high-security risks. Usually, it's more they're not safe again from other inmates, they're not safe even possibly from staff. So that would be like the bombing. That was a perfect at-risk inmate. And that's why the shift commander's got to be involved in sight checks and anytime that door is open, those kind of things.

Q In terms of the at-risk classification, does an inmate's health care condition make them at risk?

A I don't think in regards to this policy that's what we were looking at.

Q It's more of the things you were talking about?

A Uh-huh.

Q In terms of other people harming inmates or something like that?

A Yes. Yes.

Q So kind of tell me, in terms of conducting sight checks, in terms of roving through the jail, does a particular detention officer have to do a certain number of sight checks in a row? Can it be anybody to go out each 15, 30, 60 minutes, whatever the applicable time frame is? Is there any continuity expected or does just someone have to do the sight check? Tell me about that.

A Well, it's really somebody -- anybody can do a sight check. You are -- the way the staffing is, is you've

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got what's called a floor rover. And that floor rover, one of their main jobs is sight checks. But in lots of cases, because things are happening -- attorney visitations, chaplain visitations, pulling for court, all sorts of different things -- of course, they've got other tasks. So if DST, which is the change-out team for laundry, if they're in the pod, they can do a sight check. If commissary is in there, they can do a sight check.

So they all kind of help each other stay within, depending on what the housing is, within the hour, the 30 minutes, or the 15 minutes.

Q In carrying out a satisfactory execution of the sight check policy, does the County expect the last person to have done a sight check to communicate to the next person doing a sight check if a particular inmate is having, perhaps, some serious medical issues? Is there any type of information relay there?

A Usually, at the end of the shifts, there's kind of a briefing from one rover to the oncoming rover of concerns, red flags, that kind of stuff. There's nothing official, but they usually do a lot of pass-on to each other. Usually, if there's a concern, that rover that's identifying the concern deals with that concern right then and there.

Sorry. I am cramping. (Indicating.)

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Q Well, and I forgot to give you the other standard rule at the start. If you need a break, you tell me. You're not hostage here all day. So I may call a break, but just let me know.

A Okay. Thank you.

Q As long as you fully answer any question pending.

A Okay. Very good.

Q And so there -- when there is a change in the shift of the floor rover, there is some expectation of an information relay if there's a serious issue?

A Yeah. And there's what's called a rover's log. And, usually, they will document things in that rover's log too, in case they can't, you know, verbally get to that oncoming shift. And so that's usually what you do at the beginning of your shift is refer to that rover's log to see what's happened on the shift prior.

Q And in complying with the sight check policy in filling out a responsible rover's log, is it the County's expectation that potentially serious medical episodes would be a topic of discussion or logging in that log? Would that be important enough to include in that process?

A It could be. I would be -- I would think more that, if it's a serious medical issue, that's going to be notified to medical.

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Q But would it also be a part of that --
A It could be.
Q -- rollover process --
A It could be.
Q -- between the floor rovers?
For what length of time did the sheriff's office operate the jail? I know the handover was July 1 of 2020.
A Right.
Q How long did they handle it before that?
A Oh, goodness. Forever.
Q Since it was built?
A Yeah. I believe so.
Q It was built in '91. Is that right?
A Yeah. There. But they were -- they had it --
Q Before?
A -- of course at the courthouse even. Yeah.
Q Yeah.
Now, as of August 2019, the events that give rise to our case here today, Turnkey Medical was the medical provider at the jail. Correct?
A Correct.
Q Okay. Now, I don't -- we don't need to go way back in history, so I don't mean -- intend to do that.
But do you recall when Turnkey began their

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medical operations at the jail?
A They followed Armor Correctional, out of Florida. I don't remember the date.
Q Okay. And that's okay. I probably should have introduced this first. Exhibit 3 to your deposition is going to be the contract with Turnkey. And this particular contract produced in this case is July 1 of 2018 to June 30th of 2019.
Do you see that?
A I do.
Q I understand -- would that have been, to the County's recollection, when Turnkey first started? July of 2018? Or perhaps was there another term before that?
A I think there was a term before that.
Q Okay. Now, you mentioned Armor?
A Yes.
Q They previously handled medical services at the jail. Is that true?
A That is.
Q Do you know the general time frame of when they were in that role?
A No. I know they were before Turnkey and after Correctional Health Care, and that was early to mid 2000s.
Q Yeah. And the next one I saw was, yeah, Correctional Health Care Management?

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A Uh-huh.
Q Something like that?
A Uh-huh.
Q And they predated Armor?
A Correct.
Q Okay. And so why did the County move from Armor to Turnkey?
A That, I don't know.
Q Okay. Do you know why the County moved from Correctional to Armor?
A No.
Q And so we've got Exhibit 3. We've got the Turnkey contract. We discussed that time frame.
Exhibit 4 to your deposition appears to be an amendment to that agreement, among other things, extending the date through June 30th, 2020. Correct?
A Yes.
Q So Turnkey served in their medical role up until the end of the handover to the Trust. Correct?
A Correct.
Q Okay. So I am going to go back on the screen to Exhibit 3, to the base contract. And I am going to go to page 2. I am looking at Roman numeral 1, and under that 1.1 "Scope of Contract."
Do you see that?

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A Yes, I do.
Q And it notes that contractor, who is Turnkey:
shall be the sole supplier and or coordinator of the health care delivery system at the facility. Contractor's responsibility for the medical care of an inmate commences with the commitment of the inmate to the custody of the facility and ends with the release of the inmate.
Do you see that?
A Yes.
Q So in other words, under this provision and other parts of the contract, is it the County's understanding that the medical duties in operating the jail were solely on Turnkey and no one else. Is that accurate?
A Yes.
Q Okay. And under the contract, detention staff at the Oklahoma County Jail were not expected to render medical care or make medical-related decisions. Correct?
A Correct.
Q And that duty that is on Turnkey, that we're discussing here right now, would that include identifying and properly supervising detainees with serious medical needs?
A Sure.
Q Okay. And that's their sole medical duty under

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the contract. Correct?
A Correct.
Q And that's the County's understanding of that's Turnkey's sole duty and not the County's. Correct?
A Correct.
Q And that sole duty that we have placed on Turnkey, it would also include recognizing and responding to medical health emergencies. Is that true?
A That's correct.
Q And that sole duty that's on Turnkey and not on detention staff would also include making sure detainees with emergency medical needs receive timely and appropriate care?
A Correct.
Q And that duty you have described, that sole duty from the contract on Turnkey, would also include making decisions regarding referrals or transports for outside care. Correct?
A Correct.
Q And now I am on Exhibit 3, page 4, paragraph 1.6. And that pertains to off-site care and hospitalization. Correct?
A Correct.
Q And it notes that:
Contractor will arrange for off-site care and

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hospitalization for inmates who, in the opinion of treating provider and of the medical director, require hospitalization or care beyond the capabilities of the facility.
Do you see that?
A Yes.
Q Okay. And it's the County's understanding on what we have already talked about -- I think you already answered this. So my apologies if I am being redundant here.
In 1.6 here, on off-site care, that duty rested solely on Turnkey. Correct?
A Correct.
Q Pursuant to the written contract signed by the County?
A Correct.
Q And again, just to be sure, that duty, that sole duty under the contract that is off of the County and onto Turnkey, would also include making a determination if the care level at the jail -- or sorry. -- the care level needed for the inmate exceeded what could be offered to him or her at the jail?
A Correct.
MR. TABOR: Okay. Let's go off the record real quick.

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(Short Recess from 9:57 a.m. to 10:11 a.m.)
Q (By Mr. Tabor) Now, in August of 2019 -- actually, scratch that. I got ahead of myself. I want to go back to the Turnkey contract at Exhibit 3, that we've been looking at. I would like to go to page 20 of that.
And do you see that it appears that contract was executed by Turnkey. Correct?
A Correct.
Q And by Sheriff Taylor. Correct?
A Correct.
Q And by the County. Correct?
A Correct.
Q And so would it be accurate to say that the County and the Sheriff's Office would expect its personnel to follow the written contents of this contract?
A Correct.
Q Now, in August of 2019 regarding physician care at the jail, was it the practice at the jail to have a physician always evaluate a detainee when that detainee presented to the jail or returned from a hospital visit, or did this depend on the circumstances?
A I think it depended on the circumstances.
Q And what circumstances were those?
A In cases where they were sent from the facility to, usually Saint Anthony's, upon return, then usually the

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physician would do a follow-up. On new intakes, unless there was something identified by his or her medical staff that was severe, he may not see them until whatever the time frame was that was outlined in their policy.
Q As of August 2019, tell me what training, if any, the jail staff, the detention staff, had regarding detainee and inmate medical care, generally.
A So they have a training block on CPR and First Aid, and then that gets -- depending on who the organization is, that gets updated every two years or every year. And there's a command class that I actually used to teach. I don't recall if it was being taught that late into 2019 or not, but it -- it talked about just command and control. And in that -- in that class, we talked about medical being the sole decisive factors in medical care, that kind of thing. As an officer, you make a recommendation to medical, but medical has that final say of patient care.
Q And similarly speaking, tell me what training, if any, the jail detention staff had regarding recognizing emergency medical situations for detainees.
A I want to say pretty much anything in regards to that topic was around suicidality, mental health kind of stuff. I don't recall -- I mean, again, our contract was with a medical provider. So I don't -- I don't think they

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got any training specific to medical signs or anything like that. If they had a concern, they went to medical.

Q As of August '19, tell me what training, if any, the jail detention staff had regarding what to do if medical staff were potentially not properly admitting or paying attention to a detainee or inmate.

A They were instructed -- I don't know that there was a training curriculum, but they were always instructed to notify medical, and if they felt there wasn't medical care being provided, then to involve their shift commander. And that shift commander would then work with the charge nurse on what needs to happen.

Q So there was some expectation or follow-up expected of the detention staff to potentially do something if it was deemed the medical staff was not doing their job. Correct?

A Correct.

Q Okay. Tell me what training, if any, as of August 2019, the jail detention staff had regarding conducting proper sight checks.

A That is a basic class that they have in the academy, as well as in-service based off of the jail standards.

Q And tell me what you mean in this context by "in-service."

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A They go through an annual in-service after their initial academy. And the State Health Department Jail Inspection has outlined, as well as ACA, has outlined specific topics that they have to be trained on initially, as well as annually. And so they would have been referred to the policy, how to conduct a sight check, flesh and movement, you know, all the things that the state jail standards says.

MS. WILLIAMS: Excuse me. What were the words?

THE WITNESS: Flesh and movement.

MS. WILLIAMS: "Flesh"?

THE WITNESS: Uh-huh.

MS. WILLIAMS: "And movement." Okay.

Q (By Mr. Tabor) What does the County do, if anything, to ensure that the employees of medical entities, such as Turnkey in this case, are properly trained?

A I believe it's in the contract where it outlines that the health service administrator will be responsible for all of their staff, their training, their licensures, all of that kind of stuff, and that has to stay current. And they're supposed to report that to the jail administrator.

Q Are you generally familiar with the 2008 DOJ inspection of the jail or the report from 2008?

A Yes.

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Q Okay. Tell me what you generally recall about that inspection.

A Well, I believe there were 64 areas that DOJ wanted us to either implement, improve. And they ranged from sanitation issues to health care to mental health to facility structure. I mean, there was a lot of different areas that they wanted us to look at.

Q I have introduced Exhibit 5 to your deposition. Is this the DOJ report? I know I've only got the first page pulled up.

A Yeah.

Q But does this look like it to you?

A Yes, it does.

Q Okay. Within Exhibit 5, I am going to go to page 13. And here, on a subsection B, entitled, "Inadequate Health Care Services," there's another subsection B(1). This says "Inadequate Access to Medical Care."

Do you see that?

A I do.

Q Okay.

MR. HEGGY: And if you need to step closer to the screen to read it, you just feel free to do that.

THE WITNESS: Okay.

MR. HEGGY: Because he's standing over right

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next to it.

MR. TABOR: I can blow it up for you.

Q (By Mr. Tabor) In part, this section B(1) states that:

During our tour of the jail, we uncovered instances were detainees were not provided adequate access to medical care, specifically acute services, with dire results.

Do you see that?

A I do.

Q What's your understanding of what "acute services" is referencing here in the DOJ report?

A I think they were focusing on, like, chronic care topics: cardiac issues, some of those kind of things, chest pains and how those are being evaluated by medical and who evaluates them.

Q I am going on next to page 14. Let me see if I can blow this up a little bit. And I will give you time to read this top paragraph.

A Okay.

Q But this is a particular example that DOJ observed regarding a pregnant woman. You may be familiar with this and it may be old news, but I want to give you a moment to read that paragraph. And just let me know when you're done.

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A Okay. Okay.
Q Now, at least according to the information provided by the DOJ in this paragraph we just read, would you agree with the DOJ that the level of care given to this woman was not acceptable?
A Yes.
Q And would it be accurate to say that, based on the information that we have in this example on page 14 in the DOJ report, that this woman was left for a prolonged period of time outside of the jail medical area?
A Yes.
Q Okay. And is it also your understanding, based on this paragraph, that this woman made several repeated requests to be moved or to receive further care?
A Yes.
Q Now, tell me, generally, sir, about the Oklahoma State Department of Health's involvement in inspecting the jail.
A So they are the state agency that outlines basic standards for how a jail should run. So there's a list of standards. They conduct an annual audit of each jail in the state based on those standards. And then if there's any complaints that are sent to the Health Department, they will then sporadically kind of investigate those complaints.

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Q I am going to hop around a little bit, but we will get all the exhibits in. I am going to go to Exhibit 7 to your deposition. This appears to be a Health Department inspection report. Correct?
A That's correct.
Q Are you generally familiar with this type of form?
A Yes.
Q Within Exhibit 7, I want to go to page 3. And within the actual typewritten part of the report itself, under "Supervision of Inmates," it notes that, in February of 2020, which I understand is after our events here, the intercoms in cells 12 through 28 of 12 Baker were tested, producing negative results, and the intercoms in cells 14 through 25 of 13 David were tested, producing negative results.
Tell me about the intercoms. Why are those important?
A Can I step up and read my or read those plan of action notes?
Q Oh, yeah. It's quite a bit smaller, isn't it?
A Yeah.
Q Here. Let me...
MR. HEGGY: He won't bite. You can go over there and look at it.

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THE WITNESS: Well, I can see it now.
Q (By Mr. Tabor) Can you see it?
A Yeah.
Q Just holler at me if you need me to blow it up.
MS. WILLIAMS: Excuse me, Geoff. What is the date of this Health Department report?
MR. HEGGY: 2020 inspection.
MR. TABOR: February of 2020.
MS. WILLIAMS: Thank you.
THE WITNESS: Yeah. That's why I wanted to read the plan of action is because it's referring to intercoms at -- I want to say, by 2017-2018, we weren't using intercoms anymore. So the cells are equipped with an intercom in the wall. And you push the button and it goes down to central control or camera operations.
When we entered into a contract with Telmate, our at the time telephone service, they actually moved everything to the telephone itself.
Q (By Mr. Tabor) Okay.
A And so when you got on the telephone, it gave you instructions on how to access medical, how to access central control, or how to report something to the PREA line. And according to the notes, it looks like, at that point, a circuit had been blown for those cells. And Telmate fixed it that day.

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Q And we will go over it some more, but you mentioned -- let's go to 13B, 13 Baker. That's the infirmary unit. Correct?
A Correct.
Q But you said the entire 13th floor is the medical floor. Is that right?
A Correct.
Q So what would be the difference between somebody being in 13B versus 13D?
A It would be the same as in a hospital, if you're on the normal floor or if you're in, say, ICU or an acute care facility.
Q Okay.
A 13 Baker would be more that acute care that somebody -- that's somebody that medical feels they need immediate access to or the ability to monitor almost continuously.
Q Okay. And you testified about this earlier when we talked about, I think, inmate classification and housing. The County's expectation was that the medical provider would govern the transfers of inmates in and out of 13 Baker. Correct?
A Correct.
Q Okay. I am going to hop around here, but I will get back to all of our exhibits. I am going to go to

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what I marked as Exhibit 24 to your deposition. And this is another Health Department inspection report. Correct?

A Yes.

Q And you see this, the inspection date is June 25th of 2019. Correct?

A Correct.

Q Within this report, I am going to go to page 4. I will let you read that. I've just got a few questions, but I will let you read that for a minute.

A Okay.

Q And so the Department of Health in this case found that the sight check policy was not followed. Correct?

A Correct.

Q Because this individual had -- had only done three sight checks during a 12-hour period and had falsified the sight check log. Correct?

A Correct.

Q Do you know what inmate this is in regards to?

A I don't.

Q Okay. And -- and why is this of concern if sight checks are not being performed with enough frequency, as required by the policy?

A Well, lots of reasons. The inmate may not be in the cell for a period of time and we would not know

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that. They could be having a medical issue and we would not know that. For purposes of internal investigations, if they are deceased, we don't even know when that time of death has taken place because of sight checks.

Q And a part of that, too, would be that the sight check needs to be performed so that the analysis of -- what did you say -- flesh and movement can be done so that the inmate can be individually viewed. Correct?

A Correct.

Q Okay. I am next going to go back to Exhibit 8 to your deposition. This is going to be a November 7th, 2014 inspection, but our letter is dated November 30th, 2017.

Do you see that?

A I do.

Q Here, on the -- here. Let me blow up the response, in case you need to review it. The Health Department noted here, in this November 30th, 2017 letter, that three inmates were handcuffed to a rail standing unattended, waiting to be escorted to their cell, and that inmates left unattended and confined to their cell hollering and yelling through the bean hole.

Do you see that?

A I do.

Q Why would those be issues of concern, if they

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are, to the County?

A Number 2, I am not sure what -- what the State was seeing was the issue there.

Q Okay.

A Unless those individuals were in the wrong cell. Because, to me, it sounds like, right there, they were confined to their cell. I don't know what they were hollering.

I know DOJ and the State has always had issues with the facility and handcuffing individuals to bars in the -- as a waiting area. So that would be -- that would be their issue there for Adam pod. And our response, usually when -- when we were found in deficiency for that specific thing, usually we would remove those bars and go to a different procedure. And it looks like that's what we had written there, that the bars were removed from that area.

Q Now, in the recommended plan of correction from the Health Department, one of the recommendations was to conduct meetings with the sheriff, county commissioners, et cetera, to find a solution to hire more detention facility staff.

Do you see that?

A I do.

Q And why would that help alleviate some of these

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concerns from the Health Department?

A The way the building was designed, it was very cumbersome for staff the way they designed it. So our authorized number probably at that point in time was 420 security staff and civilian staff. And DOJ always felt like we needed more staff than that to be able to have -- they wanted direct supervision. That jail was built for indirect supervision. So to make it direct supervision, it would almost double the amount of staff required to meet that.

Q And I know what you're saying, but just to clear it for the record, what do you mean by "direct supervision" in the jail context?

A "Direct supervision" would be, in the living area with the inmates, a staff member is located 24/7. This jail was built with separate pod offices that you -- you don't have that one-to-one contact. And there's four of them per floor, which would require a rover to be able to respond to situations and then a pod officer in each one. So that would be five officers per floor. So it would at least double the amount of staff that was allocated.

Q And a direct supervision system, as I understand, would be more desirable. Correct?

A Absolutely.

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Q And why -- ultimately, why is that?
A One, you're -- you're visible, you're building a rapport with those inmates. So it curbs behavioral problems. And your response, obviously, is quicker to anything because you're right there in the pod. There are pods that are direct supervision, and that -- that's up on 13, based on the acuity. And then there's one assigned to segregation because of the acuity, but the rest would be considered indirect.
Q I am next going to go to Exhibit 9 to your deposition. This is also a November 30th, 2017 inspection document from the State.
Do you see that?
A I do.
Q Okay. Within this exhibit, I am going to page 2. Well, this is the same page we looked at. And you see -- I'm sorry to be redundant. Okay. Scratch that. We've got a duplicate here.
I am next going to go to Exhibit 11 to your deposition. This is a -- I will submit to you it's a 2007 inspection report of the jail. And we're certainly not going to read everything on here. I don't know about you, but I cannot read a lot of this.
Within this exhibit, I am going to go to page 3. Now, at the bottom of page 3, do you see this note in

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handwritten form that there appears to be staffing issues? And can you make this out right here? (Indicating.) "As the..."
A As the -- "there appears to be staffing issues, as the common" --
Q "Excuses"?
A "Excuses for something on sight checks is because of lack of sufficient staffing."
Q So it's -- so, perhaps, does it appear there were issues with sight checks at this time and one of the explanations or blames was insufficient staffing. Correct?
A Correct.
Q Why -- and, again, not to have you repeat your prior answers, but why would insufficient staffing at the jail impact reasonable sight checks getting carried out?
A Because of the multitude of tasks that are required. It would be -- it would be difficult -- if you're short-staffed, it would be difficult to get the tasks and the sight checks done consistently. I think that's why -- it was about this time, because that's -- Major Bobby Carson was the jail administrator.
I believe it was about this time where we implemented what we had talked about earlier, where other people that go into the pod can also do a sight check, to supplement that.

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Q But as we noted here, even in 2017, ten years after this report, the State Department of Health was still showing concerns of insufficient staffing. Correct?
A Correct.
Q I am next going to go to Exhibit 12 of your deposition. And I will represent to you this is a compilation of several inspections at the jail from the State Department of Health, 2008 to 2010. Now, within this exhibit, I am going to go to page 26. And we will look at...
Now, one of the standards that the Health Department cited -- and we're on Exhibit 12, page 26 -- was adequate medical care being provided at the facility. Do you see that?
A I do.
Q And the State Department of Health noted that this standard was not met because the facility failed to render aid. Do you see that?
A I do.
Q Now, in the plan of action, the State Department of Health is discussing the County sight check policy. Do you see that?
A I do.
Q So from the County's perspective, what is the relevance, if any, of the sight check policy and carrying

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that out to medical care detainees or inmates?
A Well, again, to -- to reassure flesh and movement, to evaluate if that individual is okay in the cell, is safe, secure, those kind of things, for escape reasons as well as medical reasons.
Q Now, within this same Exhibit 12, I am going to go to page 33. And these are all scanned in different, so I need to rotate some of these.
State Department of Health is still discussing adequate medical care here, but one violation they mention is "a prisoner was not seen by a physician until after this inspection date. He was put on antibiotics before he was seen by a doctor."
Do you see that?
A I do.
Q Now, as you testified earlier, and you can correct me if I am wrong, the decision on whether a particular detainee or inmate needs to see a physician, the County expects the medical provider, in this case Turnkey, to solely handle that decision making. Correct?
A Correct.
Q Okay. Within Exhibit 12, I am now going to go to page 71. And we're now on to an inspection from 2009, January of 2009. Again the State Department of Health is discussing adequate medical care in the -- in the

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regulations. And the State Department of Health noted that:

This standard was not met because -- redacted -- returned to the 10th floor after each medical visit instead of being on the 13th floor, where he could be closely observed.

And so is this saying that -- is it my understanding that this particular inmate needed to remain on the 13th floor because of his or her medical condition?

A That's the assumption they're making. I don't know what the medical issue was, but yeah. That's what they're saying is they feel -- the Health Department -- that he should have been observed closely on the 13th floor.

Q Okay. He should have been kept to be more closely observed by medical staff. Correct?

A Correct.

Q Okay. Within Exhibit 12, I am going to go forward to page 139. And again, as you can see, the State Department of Health is still discussing the adequate medical care standards.

Do you see that?

A Uh-huh. Yes.

Q Okay. And I know we don't have a lot of information here, but the State Department of Health is

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noting that this standard was not met because -- redacted -- was not kept in a location where he could be observed.

Do you see that?

A I do.

Q And why is observation generally, whether it's medical staff or detention staff, important in terms of making sure adequate medical care is given?

A I would assume based on the medical acuity. I mean, I don't know what was going on with this individual, but that would be the reason you would want them in close observation is because of the acuity of their medical status.

Q And then, lastly in Exhibit 12, I am going to go to page 150. And the standards we're still talking about here are rendering adequate medical care, and the alleged violation here is that an inmate was without a wheelchair for a period of time.

Do you see that?

A I do.

Q Why would that be something of concern?

A Just, I mean, mobility reasons for the individual. I mean, instead of -- for whatever reason, they needed a wheelchair to move. So mobility would be an issue for that individual without the wheelchair. So...

Q Could -- you talk about "mobility." Is another

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important part of mobility and having a wheelchair being able to communicate or interact with other people if there's something going on?

A No. I would see it more as just, you know, just basic movement, for that individual to be able to move and stretch and get blood flow and -- I am not a medical professional, but those are some basic things that I would think would need to be important for an individual in a cell.

Q And so, under the standards and practices of the County, tell me how it works with detainees or inmates in their cells who would otherwise need a wheelchair to get around. Is the practice to always have a wheelchair? Tell me what happens there.

A Well, that would be another one of those that falls into the classification policy. And if they need a wheelchair to be mobile, then they would have to be on the 13th floor and they would be given a wheelchair. Unless it's just they can move, they can move about the cell, they just can't move long distances, then that wheelchair would be located somewhere close, so when they had to go see medical or go to an appointment, they had a wheelchair. So it just really depends on that individual and the need.

Q So -- and so I am just -- I am not trying to twist your words. I just want to make sure I understand it

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right. So you're free to correct me.

If the detainee -- we're talking about giving him or her a wheelchair in the cell. If that person cannot move at all, cannot move at all without a wheelchair, the expectation is to have a wheelchair with them in the cell?

A And that -- that would be a doctor's order. That would be the physician's decision. And for whatever reason he or she could say, "No, I want them in an upward position, so they need to have a wheelchair." It could be likely that they say, "No. He's fine. He can be in a prone position. Just anytime he leaves, he needs to be in a wheelchair." But that would be a physician's order.

Q That's going to be a medical determination the County would delegate to Turnkey. Correct?

A Correct.

Q Okay. Tell me, generally speaking, about the -- about command meetings or command meeting reports. Is that something you're familiar with?

A Well, we had -- monthly, we did a command staff meeting. And that was jail administration and the supervisors. So sergeant and lieutenant level. And we did that just to talk about -- we talked about all sorts of things, maybe issues of things that were coming up, tours that were coming up. We did positive feedback in those meetings. Those kind of things.

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The sheriff would do a command staff meeting with his command, and that was all majors and sometimes captains. And that could involve whatever topics the sheriff wanted. It could involve a death in custody. It could involve just a global picture for the sheriff's office. And those were not scheduled. Those were random.

Q And so would it be accurate to say things getting brought up or discussed at command meetings were things that the County deems important to get on the table and address?

A Yes.

Q I am going to introduce Exhibit 13 to the deposition. This is a June 27th, 2016 "Minutes of Command Staff Concerns."

Do you see that?

A I do.

Q So would this be minutes of the types of meetings you're talking about here?

A This would be one of the sheriff's ones.

Q Okay.

A That are random.

Q Okay. And when you say "random," is that when somebody makes a request for the meeting or is there some type of --

A Usually the sheriff.

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Q Okay. So when the sheriff would demand it?

A When the sheriff decides. Yeah.

Q I believe you were present at this one. Correct?

A Yeah.

Q Now, at the bottom of this -- of these minutes, Exhibit 13, when referencing new cadet officer training, the minutes note that "reiterate to existing staff the importance of proper sight checks and the importance of communicating with supervisors about inmates at risk."

Do you see that?

A I do.

Q So for this to be included in the sheriff's meeting here, were there concerns at this time in June of 2016 about properly executing sight checks?

A There could have been. That was a topic that we never stopped talking about. I mean, that was pretty much every meeting was the importance of sight checks, but also that -- and we talked about this earlier -- the communicating with supervisors. And that kind of plays that role, where if you're power struggling with medical about an at-risk inmate, then you involve your supervisor.

Q And so during your time here working for the sheriff's department at the jail, properly conducting sight checks has always been a topic of concern like this for the sheriff?

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A Well, and I don't even know "a topic of concern." It's always been a topic.

Q Okay.

A It's just one of those things that's very important, that we constantly reiterate to staff.

Q But you would agree with me that if this is -- in the context this is getting brought up in, in the minutes for the sheriff's meeting here in Exhibit 13, this is being flagged as something to improve. Correct?

A It could be. It could be, again, just that basic topic that we always talked about.

Q And then the latter part of that sentence references the importance of communicating with supervisors about inmates at risk.

And why is that important again?

A Again, that would be one of those that we don't make medical decisions. We emphasize that to the staff. There's NCCHC standards that kind of outline security doesn't make medical decisions. But if you felt there was something going on and proper care wasn't taking place, you need to get your supervisor involved. And that's where I was speaking earlier, where that was usually the shift commander, and then the shift commander would get with the charge nurse. And between those two, they would discuss

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that topic.

Q Okay. And so, again, something had to have been happening or some concerns had to have been present for this to be discussed in the fashion of Exhibit 13. Correct? Were there complaints? Were there issues?

A It could have been complaints. And, again, it could have been -- that's how often we talked about those, because they were so important. It could have been just standing agenda.

Q I am going to move next to Exhibit 14. This is going to be the "Serious Incident Review Policy." Do you see that?

A I do.

Q And you testified about some of this earlier, so I will try not to be too redundant. And so if I remember your earlier testimony right, the "Serious Incident Review" portion of reviewing an incident or a death or an event is the -- is the review undertaken by the County, by the sheriff. Correct?

A By the sheriff.

Q Because we talked about the Morbidity and Mortality Review would be by the medical provider. Correct?

A Correct.

Q Okay. And then what was the third potential

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review you mentioned?
A We were talking -- well, we were talking about quality assurance.
Q Quality assurance?
A And that didn't necessarily involve these topics.
Q Okay. So tell me the purpose and the general ambit of the Serious Incident Review policy and process.
A So there -- it kind of goes hand in hand with duty officer as well. So we broke down topics that could take place into a Priority A or a Category A and a Priority B. That let the supervisors know, if a Priority A took place, that was an immediate notification to administration. So if it was after hours, that would be the duty officer.
If it was a Priority B, that could be the next-day notification. Those topics then -- usually Priority A's were the ones that then were referred to investigations. And then investigations at that point, usually admin would completely step out of it, to not skew the investigation or play a role in it. And the investigators would investigate that and then come back with a Serious Incident Review and brief all of administration on their findings.
Q Okay.

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MS. WILLIAMS: Is this Exhibit 14?
MR. TABOR: Yes.
MS. WILLIAMS: Thank you.
Q (By Mr. Tabor) And so an inmate death -- I know you testified about this a moment ago.
Are there inmate deaths that don't trigger Serious Incident Review?
A No.
Q So all inmate deaths are going to trigger some form of Serious Incident Review. Correct?
A Correct.
Q Okay. I am next going to go to page 5 of Exhibit 14, Roman numeral 5, entitled "Serious Incident Review."
And it talks about some of the processes the jail administrator can undertake. Correct?
A Correct.
Q And so who was the jail administrator as of August of 2019?
A Will Blaik.
Q Will Blaik?
A Uh-huh.
Q Is that a "yes"?
A Yes.
Q Okay.

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A Sorry.
Q That's okay.
I am next going to go through some of the Serious Incident Review minutes or documents that we have, themselves. And do you see the subject is -- and this is January 3rd, 2018 "Requested list of Oklahoma County Jail" -- is that "Internal Affairs"?
A It is.
Q "Cases in which staff was found to have acted in violation of facility policy in the last 12 months."
Do you see that?
A I do.
Q So would it be routine for the sheriff's office to be requesting a list like this or is this something that came up sporadically? Tell me, was this just something routine, saying, "hey, every year we ask for a list or a meeting of where our staff has violated policy," or is this just something that happens?
A I have never seen that document. So I don't -- I don't know why that would have been created.
Q But, to your knowledge, this is not some type of routine, standard request that always happens?
A No. Usually, it's part of the Serious Incident Review for that, say, that quarter. And you would maybe have that information about those cases that were presented

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that quarter, not a blanket list of cases for the year.
Q Okay. And is it concerning that, here in this list, there's a total of 16 responsive cases where there's been violations?
A Yeah.
Q Now, here at the top, there's an incident from **2017 with a corporal -- or the death of an inmate. It was a Nguyen, "Corporal Brown terminated for sight checks not being conducted."**
Do you see that?
A I do.
Q And then in a 2017 death of an inmate, Mr. Willis, an employee -- is that Detention Officer Newkirk?
A It is.
Q DO. Terminated for improper sight checks.
Do you see that?
A Yes.
Q Okay. And again, I -- I -- not to go over this again, but here, the County, in Serious Incident Review, is specifically flagging improper sight checks in the context of inmate deaths.
Why do those two things go together? Why are those important?
A Again, because, for investigative purposes, we

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don't have information on what happened, necessarily, with that death, how long it had taken place, because of the sight checks not being done correctly. And I mean, it's a state standard and a policy.

Q And there's a third 2017 incident involving inmate death for a Davey Jimmerson. It notes that "Central control failed to log all medical calls. Changed procedure, added a second medical line, inconsistent sight checks, referred to jail admin."

Do you know what that's talking about when it says "changed procedure, added a second medical line"?

A Well, I know -- I don't know what "added a second medical line" is. They -- central control -- so back to when I was talking about Telmate and the phone system, so they have the ability to call camera operations. Camera operations would simply say, "What's your medical emergency," and then they would log that.

And so in that, it looks like they failed to log those medical calls. So once again, for investigative purposes, we don't know how many times that individual actually called medical to try and...

Q Hmm. So as we were discussing earlier with the other two, in January of 2018, the Serious Incident Review had flagged three different sight check violations specifically regarding inmate deaths. Correct?

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A According to that document. Yes.

Q Okay. And that's of concern to the County. Correct? That there's three violations?

A Correct.

Q I am going to next go to Exhibit 16, which is another Serious Incident Review Minute from January 10th of 2018. Do you see that?

A I do.

Q The very last entry here mentions the 2017 death of an inmate, Larry Prather. Do you see that?

A I do.

Q And it notes that "sight checks not complete." Do you see that?

A I do.

Q Okay. And is that of concern to the County that there is an inmate death and the sight checks revolving around that death were not complete?

A It is.

Q And again the Serious Incident Review process would be flagging proper sight checks with inmate deaths because the expectation is that the detention staff conducting the sight check has to view and evaluate the inmate. Correct?

A Correct.

Q But even if the sight check is getting done

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timely and it's routinely getting done, a proper sight check still requires a proper analysis of the inmate in terms of movement and flesh. Correct?

A Flesh and movement.

Q Okay. I am going to next go to Exhibit 17. This is going to be the Serious Incident Review Minutes from May 10th, 2018. Do you see that?

A I do.

Q There's another inmate death here for 2018, an Inmate Nicholas Green. Oh, no. Never mind.

On the "Discussion" section, staff shortage is one of the topics of discussion in May of 2018.

Do you see that?

A I do.

Q And, you know, I don't want you to have to repeat everything from earlier, but when it says "Staff shortage is being discussed by the Serious Incident Review process," is that similar to the staff shortage you were talking about earlier? Those same concerns with -- what did you call it? Direct?

A Direct supervision.

Q Direct supervision?

A Probably not. That's probably more in regards to, you know, now having to be very creative with other teams helping and doing that or dismantling specialty

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teams, those kind of things, to help with the staff shortage.

Q It also mentions cell doors. Do you know what would be a problem or issue for the Serious Incident Review process to be flagging cell doors in 2018?

A Yeah. So a lot of cells, especially on the eighth floor, a lot of inmates were destroying their cell locks so they could get out and go visit other inmates, those kind of things. So we were constantly battling having to make sure those doors were not circumvented.

Now, that was -- that was probably the time, I think we, in 2018, had already gone and installed a whole new locking system on 8 and 4. So we were -- we were constantly talking about cell doors and trying to find the funds to do that throughout the entire jail.

Q I am going to next go to Exhibit 18, which is an October 18th, 2018 Serious Incident Review Form. Do you see that?

A I do.

Q On page 2 of Exhibit 18, there's an inmate death for a Clark Streetman. And there's a mention of lack of consistency with sight checks. Do you see that?

A Yes.

Q Okay. And so, similar to before, the Serious Incident Review process would be flagging the sight check

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process with inmate deaths because of general inmate safety. Correct?
A Correct.
Q That that process is, first, being done? That people are actually doing the sight check. Right?
A Correct.
Q And, two, once they're doing the sight check, they're carrying it out properly with flesh and movement. Correct?
A Correct.
Q Okay. I am next going to go to Exhibit 19. And this is a May 24th, 2017 Serious Incident Review Minute. Do you see that?
A I do.
Q And on page 2 of this minute -- hold on. Yeah. The last entry, for an Inmate Ricky Windle, do you see this one?
A I do.
Q And it mentions "sight checks not complete, found unresponsive." Do you see that?
A I do.
Q And again, that would be the same type of concern why this Serious Incident Review process is flagging proper sight checks with inmate death. Correct? As you have testified before?

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A Correct.
Q Okay. I am next moving on to Exhibit 20. And this is going to be the Serious Incident Review Minutes August 17th, 2016. Do you see those?
A I do.
Q Okay. Now, here on page 2, we're going to look at the death of an Inmate Robert Hollis here in the middle of the page. Do you see that?
A I do.
Q And it was a suicide by hanging. The Serious Incident Review process noted: "Staff failures, lack of communication from security staff to medical staff. Disciplinary action taken, medical mortality/morbidity complete. OSBI pending."
Do you see that?
A I do.
Q So in the terms of an inmate death, whether that's a suicide case or just a medical death, a natural death let's say, why is it important that the Serious Incident Review process is flagging communication from security staff to medical staff? How does that link up?
A I mean, I don't know this case specifically, but all I could assume is that this individual did not notify medical of a medical concern and they're saying that correlated with the death.

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Q And is the expectation that -- is the goal that, hopefully, there can be better communication from detention staff to medical staff if intervention could be had to maybe prevent the death? Is that one of the goals?
A Well, again, it's a best practice and it's National Commission standards that we don't make medical decisions. So we have to provide that information to medical.
Q And then you see, further down the page here, an Inmate Debbie McAbee, inmate death. "Disciplinary action taken/improper sight checks for a natural death."
Do you see that?
A I do.
Q And the concerns would be the same there. Correct? On linking up proper sight checks with an inmate death. Correct?
A Correct.
Q I am going to go next to Exhibit 21, which is going to be the Serious Incident Review Minutes from April 20th, 2012. Do you see those?
A I do.
Q Just real quick on this one I had a question. There's a suicide here of a Jeff Darling. It said: "Inmate was found hanging in cell. Inmate had covered his window to block any view."

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Tell me why having a view on the inmate is a -- well, tell me why that's an issue.
A Well, again, it's the basic premise of doing a sight check. You have to be able to view inside the cell and see flesh and movement. So with a window being blocked, the state jail standard says that individual -- that door cannot be breached. You have to get backup to breach it because you don't know what the inmate is doing on the inside, but it needs to be breached to find out what's going on.
Q Okay. And the Serious Incident Review process noted that corrective actions were taken, policy and procedure not followed. During the sight check, the officer should have removed the paper which inmate placed in the window to block the view.
That would have been the best practice. Correct?
A Correct.
Q I am going to go next to Exhibit 22, Serious Incident Review Minutes from August 17th, 2011. Do you see that?
A I do.
Q I am going to go to page 2 there. There's an inmate death for a William Horton. Do you see that?
A I do.

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Q And it said the ME ruled his death was natural due to kidney disease. Do you see that?
A I do.
Q It discusses the incident, which you're welcome to read, but it notes video and sight checks were reviewed and looked good; however, one officer performed an extra sight check and did not conduct it as trained.
Do you see that?
A I do.
Q And so this goes back to officers can do an adequate number, and in this case even an extra number of sight checks, but if the actual substantive sight check is not carried out, that's an area of concern. Correct?
A Correct.
Q If it's not done correctly?
A Correct.
Q Okay. And that was exactly the case here in the death of Mr. Horton. Correct?
A Yeah. That's why the officer was terminated --
Q Yes.
A -- was solely because of inadequate.
Q And then just below that, a case -- a death involving a David McClain was a suicide case. The officer saw the inmate hanging and failed to render aid immediately. And the corrective action was that that

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officer was terminated. And the OSBI, at least at that time, was considering filing criminal charges; and if they didn't, the sheriff's office would seek criminal charges.
Do you see that?
A I do.
Q Do you recall this incident?
A I do not.
Q Okay. But either way, this was another concerning situation in 2011 of an officer failing to carry out the observation of an inmate. Correct? Or to intervene to prevent --
A To intervene. Yes.
Q -- harm to the inmate?
Because there's some level of involvement that's inspected -- expected of the officers. Correct? When they're conducting sight checks?
A Correct.
Q And so in the case -- I know Mr. McClain's case sounds like an extreme case of a suicide that had taken place or was taking place, but backing up from that, if the officer suspects an emergency, there's some expectation that they intervene. Correct?
A Correct.
Q Okay. And the failure to do so in the case of David McClain potentially led to criminal charges being

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filed. Correct?
A Correct.
Q I am next moving on to Exhibit 23. This is -- do you see the minutes, the Serious Incident Review Minutes, from October 12th, 2011?
A I do.
Q Okay. We're going to go to page 2 of Exhibit 23. The bottom paragraph after the inmate death section notes that Lt. Chuck Brewer, Special Investigation Division, advised corrective actions needed, slash, sight check issue was addressed and solved.
Do you see that?
A I do.
Q Okay. And so, again, here in this particular review, signed in October of 2011, carrying out proper sight checks in the context of inmate deaths was again flagged as an item of concern. Correct?
A Yes.
MR. TABOR: Okay. I think right now is a good point for a break. We can go off the record.
(Short Recess from 11:22 a.m. to 11:27 a.m.)
Q (By Mr. Tabor) We're back on the record. We have already gone through Exhibit 24. I am going to go through Exhibit 25 to your deposition. And this is the May 2021.

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I know this is after our events of this case, but this is the NIC Operational Assessment. Do you see that?
A I do.
Q And are you generally familiar with this assessment?
A Well, NIC would be the National Institute of Corrections. That would be a technical assistance that was requested by the agency. And this would be under the Trust, so I am not familiar with this at all.
Q Okay.
(Discussion held off the record)
Q (By Mr. Tabor) I am going to ask you just a few brief questions about this NIC report, even though I know that, with the timing of it and the handover --
A Okay.
Q Within this report, Exhibit 25, I am going to go to page 12. The very bottom paragraph notes that it's talking about the period of 2009 to the handover of July 2020.
Do you see that?
A I do.
Q And it says:
At the same time inmate health care has been extremely troublesome with it identified that 45

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inmates have died in custody between 2014 and 2019. Since January 2021, six inmates have died. Of course, some of these were natural, but one was due to a hostage situation. However, these numbers are disturbing.

Do you see that?

A Yes.

Q And do you agree with that assessment that it is disturbing the number of deaths between 2014 and 2019 at the jail?

A The number, obviously, is -- is disturbing. Unfortunately, natural causes, I don't know how that breaks down to suicides and natural causes and all of those kind of things. Unfortunately, with, you know, 50,000 people going into that jail every year, naturally, you're going to have natural-cause deaths. So yeah. I don't like the Number "45."

Q But natural cause deaths, there -- there could still be things that either the medical staff or the detention staff could do to treat or prevent a natural-cause death. Correct?

MR. HEGGY: Object to the form.

Q (By Mr. Tabor) Again, talking about -- I think this sentence is talking about the period of 2009 to July of 2020. This NIC report states that, during that time

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period, "inmate health care has been extremely troublesome."

Do you see that?

A I do.

Q And do you agree with that characterization?

A I do not.

Q You do not?

A No.

Q Okay. And why do you disagree with that characterization?

A Maybe -- maybe at the start of 2009, but towards 2018, 2019, I think Turnkey was doing a good job. I think some of the things that DOJ was still watching us for was mental health and medical. And when they did their follow-up audit in 2019, they felt like we were pretty much in substantial compliance with things. So I think towards the end of that time frame, I think things were looking much better.

Q Now, we're talking about this timeline of 2009 to 2020. And your testimony is that you think things were better when Turnkey -- Turnkey was doing a better job? Is that...

A I think towards the end of our stint with Turnkey, they were doing a better job.

Q And I know you were mentioning some -- some

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time frames a minute ago. Could you hammer that down?

When you say "towards the end of our stint, when they were doing a better job," what time frame would that be?

A Because I was more involved with them, I can speak to those dates. But I think probably 20- -- certainly 2018 and 2019.

Q Okay.

A And then, of course, the end of 2019 is when DOJ came in. And they felt pretty much the same thing that I was observing, was that they were starting to meet all of those standards.

Q And so I will ask you kind of this -- and I understand. I -- your answer makes sense to me on how you would disagree with this -- this sentiment at the bottom of page 12 of Exhibit 25 for 2009 to 2020. But what about 2009 to 2018? Would you agree with the NIC report for that time frame before this Turnkey time frame you're describing?

A I was going to say that -- that would probably involve Armor and Turnkey, both. And I think -- I mean, I think that's why we had some of the standards that were created by DOJ in 2008 was because they had some concerns of medical care and some of that kind of stuff. So I -- I would agree with that.

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Q Okay. I am next going to go to Exhibit 26 of the deposition. And this is going to be a Special Investigations Review of an inmate death of Jordan England. Do you see that?

A I do.

Q And this is a suicide case. Any individual recollections of this incident?

A No.

Q Okay. I know it's been a while. This is a 2013 case.

A Uh-huh.

Q Within Exhibit 26, I am going to go to page 6. On the "Conclusion of Facts" section, the investigator notes that Detention Officers Cody Duncan and Ronald -- I might butcher this name -- Adegoke violated OCDC policy relating to sight checks, the assurance of observing moving flesh.

Do you see that?

A I do.

Q And that all goes back to the Serious Incident Reviews. We have been through a lot of them today. Why a proper sight check and evaluating an inmate is proper especially in the context of an inmate death. Correct?

A Correct.

Q And in this case, these two detention officers

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violated the sight check policy in this particular death. Correct?

A Correct.

Q And this notes that:

Inmate Jordan England was positioned in his bunk and would appear as if sleeping when viewed through the cell window. Understandably, inmates do not like their sleep being disturbed during the night as officers conduct sight checks. However, at some point, there should be a reasonable sight check that ensures the inmate is alive and breathing.

Do you see that?

A I do.

Q So in this context, what would that actually mean? If the inmate is, let's say, laying down on his back or his side on the bed, just laying on the bed, what does a proper sight check look like in that instance, to make sure the inmate is alive and doing okay?

A It's movement and flesh. So if I see flesh, then that's one part of it. I need movement. And so that's knocking on the cell door, something to get that individual's attention to wave at me, raise their head, something like that.

Q Okay.

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A And I mean, like in this case, I am not sure. I don't recall this case. But it may not have contributed to the death, but once again, it affects the investigation and how long that individual had been expired.

Q But would you agree that, in some instances, if someone -- if an inmate is undergoing a medical emergency, is still alive, the failure to intervene and do a proper sight check could contribute to the death?

A Could.

Q So I have seen some inspection reports from the Oklahoma Department of Corrections.

A Okay.

Q Could you tell me your familiarity with that in regards to the Oklahoma County Jail?

A Yeah. So when the jail had contract Department of Correction inmates, they were housed on 10 Adam. There was 98 of them. And based on the contract with DOC, DOC was obligated to do an annual audit of the jail. They used the ACA Small Jail Standards as their audit tool. And so, annually, they would come in based on those standards and -- and do an audit.

Q And would you recall, let's say, since 2010, how many DOC audits there have been of the Oklahoma County Jail?

A I don't even remember when we got rid of the

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contract. So no. I don't.

Q But if I am understanding you right, that whole process and those inspections were premised on that contract regarding DOC inmates at the -- at the jail?

A Correct.

Q Okay. So that's why DOC inspections were even happening to begin with?

A Correct.

Q Okay. Tell me generally, what's the National Commission on Correctional Health Care?

A So that is the accrediting body for health care for prisons and jails. Well, they do more than prisons and jails, but mainly prisons and jails.

So for best practice, a jail would want to be accredited through NCCHC and ACA. And they go through a pretty rigid audit process where they go through medical files, patient care, access to care, all of those kind of things. And you have to meet -- testing my memory now. I think you have to be compliant, for NCCHC, with 100% of the standards to be accredited.

ACA separates them into mandatory and nonmandatory. And in that audit, you have to be compliant with 90% of nonmandatory and 100% of mandatory. So it's a little different.

Q And for the record, what's the ACA?

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A ACA is American Correctional Association.

Q And as of August 2019, was the Oklahoma County Jail accredited by the NCCHC?

A Both of those accreditations expired in 2019. I don't know the month.

Q And why did they expire in 2019?

A They're certifications for three years. We initially did 2012 ACA again in 2015. NCCHC we waited, because of the ACA, until 2016, did that reaccreditation. So they both expired, I think one at the beginning and one towards the end of 2019. And the reason we didn't go for reaccreditation is money. It just -- we were -- all of our policies were written based off of those standards and best practices. It didn't make sense for the County to put up, you know, $20,000 for each audit to hang a certificate on the wall. We were doing all the standards anyway. So the sheriff decided not to go for reaccreditation.

Q Okay. I am going to go back to this NIC report really briefly on Exhibit 25.

Now, I think you covered it right at the very start of your deposition on the timing and reasons on the handover in July of 2020. Correct?

A Uh-huh.

Q NIC report notes that, at the top here:

Due to the above, the County of Oklahoma chose to

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remove the jail from the sheriff on June 10th, 2019, with the creation of the Trust Indenture, Oklahoma County Criminal Justice Authority, commonly called "the Jail Trust." It became effective July 1, 2020.

Do you see that?

A I do.

Q And so would you -- and I know I asked this earlier somewhat to you, but do you know, sitting here today, any or all of the reasons why the County chose to remove the jail from the sheriff's control in June of 2019?

A I don't know all the reasons. No.

Q Tell me all of the reasons you do know, sitting here today.

A I mean, these are, of course, my opinions. I think, with the involvement of DOJ, even though we were found in compliance with all of their things in 2019, at that point some of the county commissioners had already made a move politically to do something. And so it was already set in motion. And we had asked -- as an agency, we had asked to have them do a financial trust instead of an operational trust. And the decision was to just go ahead and do a complete operational and financial trust.

Q Isn't it true that the 2019 decision to move the operation of the jail from the sheriff to a trust was a pattern of deficient jail practices?

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A I think it was based on that early on. I don't think anybody could articulate that towards the end of, when it took place, that it was still in regards to deficiencies.

Q And so for -- when you say "early on," when you **say a period that does fall under that, what are we talking about here? What time frame?**

A Well, I think the involvement of DOJ, so early 2000s. I think that set things in motion.

Q So you would agree that, at least at the time that DOJ report was rendered in July -- I believe July 31 of 2008 -- there was a pattern of civil rights abuses at the jail?

MR. HEGGY: Objection to the form. Calls for a legal conclusion.

Q (By Mr. Tabor) You can answer.

A I don't know about civil right violations. I know there were outlying deficiencies for best practice that certainly were taking place.

Q Okay. So you would agree -- I will rephrase the question.

In July of 2008, when the DOJ rendered its report, you would agree there was a pattern of deficient jail practices at the Oklahoma County Jail?

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A There were inadequate practices to meet best practice standards.

Q And would you agree with me that some of these involved inmate supervision?

A In regards to DOJ's --

Q Yes.

A -- expectations? Yes.

Q Okay. And would you agree with me -- would you agree with the DOJ characterization that there was a pattern of failing to render adequate medical care?

A At times.

Q Okay. For how long after, in your opinion, from that DOJ report, did a pattern of deficient medical care continue at the Oklahoma County Jail?

A I mean, that -- that's a hard one to answer. I think the facility initially, right at 2003, started making changes to address those deficiencies. I know, when they came back 2008 and then again maybe 2012 -- I am not sure completely on those dates. Each time, we were improving with those deficiencies, but there were deficiencies all the way until the last report, until 2019, when they came back for that last and said we were substantially compliant. So...

Q So what follow-up reports or inspections occurred from the DOJ following the July 2008 report?

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A To my knowledge, not much. They would do their audit. We would, obviously, know what they were thinking and saying. And then we didn't necessarily see a report as frequently as we would have liked.

Q But I am going to go back to this July 2008 report. After that, would you agree with me that deficient practices in medical care continued -- a pattern of those practices continued for some amount of time after 2008?

A There were still some deficiencies from that 2008 audit.

Q Okay. And you noted that, even though the jail showed improvement in that regard, there were still deficiencies flagged in the 2019 report from the DOJ. Correct?

A To my knowledge, the 2019 was complete substantial compliance.

Q And so for how long following 2008 did the pattern of deficient medical care continue to exist at the jail?

A That, I don't know.

Q But I believe, based on your earlier testimony, it would at least cover the time that Correctional Health Care was contracted, and Armor?

A It would have. I think once NCCHC was involved with the accreditation, I think at that point, a lot of

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those deficiencies had to have been compliant to receive that accreditation.

Q Now, this decision to hand over the jail, transfer the jail from the sheriff's office to the Jail Trust, as we have seen in the NIC report, the actual decision was made in June 2019. Correct?

A I know it was the beginning of '19.

Q Okay.

A I don't know specifically June, but yeah.

Q Okay. And that would have been before the August 2019 incident that brings us here today in this case. Correct?

A Correct.

Q Let's just go from -- oh, we'll go from the time of the DOJ report, since we've been talking about it, the 2008 report, until the time of the handover on July 1, 2020. Tell me about the general capacity issues that the jail has had in terms of inmate population.

A It's been a steady downslide. The focus has obviously been, with the implementation of CJAC here in the community, which is the Criminal Justice Advisory Council, their big focus has been lowering the population. So from 2008 -- I mean, I don't know the exact dates. You know, mid to late 2000s. Well, mid 2000s, our numbers were still up towards capacity.

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But towards 20- -- probably 2014 to 2019, each year, it dropped significantly with changes with some of the bond stuff. And they incorporated a program with some organization out of California for low risk, low bond releases. Some of it -- we got rid of the Department of Corrections contract. That took out 90.

There was a lawsuit with the public defenders office for those that had been adjudicated for judgment and sentenced for DOC that they are gone in 45 days. And used to, that would go for a lot -- you know, a long time. So a lot of those kind of changes helped with the lowering of the population.

Q Now, I know -- it's my understanding you can rate capacity of a jail in different ways. Is that true?

A That's true.

Q Tell me how that works.

A Well, so the capacity that we used was from the fire marshal. And that's just like any other business, how many people you can have based on exits and suppression systems and alarms and all of that kind of stuff. So we used that number. So did -- the state jail inspector used that same number.

Q Is there another metric to use when rating the capacity of a jail, specifically?

A There's -- ACA does a square footage,

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unencumbered space, day room space, those kind of things that kind of change things. I am wanting to say there's one other -- one other number, but I don't recall what that one is. But, again, we use the State Fire Marshal.

Q And so the State Fire Marshal standards, those would be the ones the jail was using in August of 2019?

A Correct.

Q So by those standards in August of 2019, would it be a fair characterization to say that the jail was overcrowded at that time?

A No.

Q And why so?

A We were substantially under the number allocated by the fire marshal.

Q Now, by the ACA standards or any other similar standards, would that be a different answer to that question?

A The only thing in regards to the ACA would be the unencumbered versus encumbered. Fire marshal doesn't use encumbered space. So it's -- it's square footage and all of those kind of things and all the other things that I said. I think we would have probably been at the maximum number for ACA's numbers in regards to square footage and unencumbered space.

Q Generally speaking, what difficulties are

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placed on the detention staff if a jail is operating at or over its capacity in terms of the inmate population?

A Inmate behavior. Time frames. Of course, being at your maximum capacity increases visitation times, increases attorney visits, chaplain visits, all of those kinds of things. So workload.

Q And in the sheriff's office experiences in operating in the jail, can an overcrowded inmate population cause some staff members to cut corners, perhaps, or expedite those duties so they don't fall behind?

A We always directed the staff not to cut corners. I mean, I can't speak to each individual --

Q Yeah.

A -- and what they're thinking, but we always talked about, you know, regardless of what's happening, do not cut corners, especially policy.

Q And I understand that. But in the sheriff's office experience, could that -- did that ever cause individual detention officers to cut corners or feel stressed or feel that they could not cover their duties?

A Again, I don't know that I ever heard a staff member say, "Hey, the reason I did this was because I am overworked and understaffed." So I can't speak to why they chose to do certain things. Regardless, the consequence was the same. They were terminated for cutting those

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corners.
Q We have talked a bit about 13 Baker and 13 David and that the transfer in/transfer out process for 13 Baker is a Turnkey question. Right?
A Collaborative.
Q Collaborative?
A Yeah.
Q So when you say "collaborative," what do you mean?
A Well, it still involves classification. Classification has to do the reassignment in the computer so everything is current and we know where that individual is. But classification can place somebody anywhere in the jail solely off of what they're doing. They cannot do that in 13 Baker. That involves -- medical has to be involved in that decision on whether or not they go in the infirmary.
Q So we talked a little bit about the State Department of Health a while ago. We went through some of those reports.
Did the State Department of Health investigate the death of Daryl Clinton?
A I don't know for a fact. I would assume they did.
Q And the County submits incident reports to the State Department of Health for inmate deaths. Is that right?
A That is correct.
Q Exhibit Number 6. And this would be the form for such a report. Is that correct?
A That's correct. Should be two pages. Yeah.
MS. WILLIAMS: What exhibit is this?
MR. TABOR: 6.
MS. WILLIAMS: Thank you.
Q (By Mr. Tabor) It's got a brief description. Correct?
A Correct.
Q Now, page 3 of the incident report, Exhibit 6, has what looks like the opening page of the investigation report. Correct?
A Correct.
Q You know, it may just be the copy I have here, but it's only the first page. Would it be typical for the County to share the entire investigative report with the State Department of Health?
A Only during the State's investigation. And they would actually have to go to Investigations to get that information.
Q Okay. So that report is not initially shared with the Health Department? Right? Only if then the Health Department follows up to investigate a complaint. Correct?
A Well, or they investigate all deaths.
Q Yeah.
A Yes.
Q Okay. Tell me -- now, we have kind of talked about this somewhat already. We're talking about Serious Incident Review, but tell me, what is the Special Investigations Unit?
A So that is a unit of certified officers, CLEET-certified officers, that take care of Internal Affairs issues. So any issues regarding staff and any -- mainly Priority A on that one policy, Priority A incidents.
They can -- they file charges on people that are inside the jail, that commit a crime inside the jail, with the DA's Office. They take care of all of that stuff.
Q And I know we talked about this when looking at the Serious Incident Review policy earlier, but does the Special Investigations Unit investigate every inmate death?
A Yes.
Q Okay.
A Unless -- I think there had been some times -- because they always notify OSBI, which is the state investigative agency. And most -- I would say probably 90% of the time, they tell Special Investigations go ahead and do the investigations. There has been some times that I think either OSBI has done a co-investigation or a separate. What separates those, I don't know what makes those decisions.
Q Who is Jennifer Peek?
A She was an investigator for Special Investigations.
Q And she rendered the investigation into the death of Daryl Clinton. Correct?
A Correct.
Q Were any employees of the county, any of the detention staff demoted, disciplined, subject to corrective action, or terminated as a result of Daryl Clinton's death?
A I don't believe so.
Q Okay. Were any employees of Turnkey Health demoted or disciplined or terminated, to your knowledge?
A Just from reading Peek's, but I never was privy to that information. So I don't know what that involved.
Q Because she made a very brief mention in her report. Right?
A Yes. Correct.
Q I am going to go to our investigation here at Exhibit 27. Do you see that?
A I do.
Q I am not going to go through the whole thing,

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but I have a few questions.

And you have reviewed this and you're generally familiar with this report?

A I have.

Q We're looking at page 3 right now. Take a minute. So here on page 3, we're looking at Peek's interview with a Detention Officer Christian Miles.

Do you see this back and forth?

A I do.

Q Okay. And Peek is asking Miles about some of the interactions Miles had with Mr. Clinton on August 10th of 2019. Correct?

A Correct.

Q And, as you have read before here today, Mr. Clinton tells Mr. Miles that he cannot move and he needs water.

Do you see that?

A I do.

Q And then Miles mentions a Charge Nurse Phyllis Miller, or "Phyllis," but her name is Phyllis Miller. And she tells Miles that Mr. Clinton is faking it.

Do you see that?

A I do.

Q Okay. "He's just been discharged from the hospital, and everything is fine."

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In a situation like this that we're looking at, with Miles and the Nurse Miller, with an inmate complaining and the nurse says that the inmate is lying or is -- is exaggerating, what does the County expect the officer to do if the officer has a suspicion that the nurse may be wrong?

A To continue to investigate it. And if he's not -- he or she is not satisfied and continues to have concerns, to then involve his supervisor or her supervisor.

Q And so for someone in Miles's position, what supervisor would that be?

A Probably the very next one would be the corporal. And if things still aren't working, then at some point in time, the shift commander needs to get involved so they can have a direct dialogue with the charge nurse.

Q So it would go from the detention officer to the corporal to the shift commander?

A It could. It could go from the corporal to the sergeant to the staff sergeant to the lieutenant, but regardless, if nothing's getting done, that lieutenant has to get involved.

Q So if nothing is getting done, ultimately, that issue, if there's a problem, has to be worked up to the lieutenant. Correct?

A Correct.

Q And could you just, in terms of an

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organizational chart or -- could you kind of build everybody up?

A Sure. So you've got a detention officer. That's an individual that's been employed for under six months.

Q Okay.

A You've got a senior detention officer, which is a detention officer with no rank but has been there longer than six months. Then your first level of rank is corporal, then sergeant, staff sergeant, lieutenant, and then captains or administration.

Q Yeah.

So as long as you're going up the chain and the highest person, if they still have a belief that something is not right, that reporting needs to continue up the chain. Correct?

A Correct.

Q Okay. So in this instance, if Miles told Corporal Mulanax and Corporal Mulanax still had concerns that something was amiss or something wasn't right, Mulanax has a duty to report it further up the chain. Correct?

A Correct.

Q Okay.

A And, usually, corporal would then go to that unit manager, which is a sergeant or a staff sergeant.

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MS. WILLIAMS: I'm sorry? Staff sergeant or...

THE WITNESS: A sergeant or a staff sergeant.

MS. WILLIAMS: Thank you, sir.

Q (By Mr. Tabor) And here, Miles indicated that he did talk to Corporal Mulanax. Correct?

A Correct.

Q I want to go to the top of page 5 here. We're still in the Peek report, Exhibit 27. Peek is asking Miles about the sight checks were every 30 minutes, Mr. Clinton was vocal.

Miles then says:

Yes. Like I said, with everything that popped off, I had multiple reports that the lieutenants were breathing down my neck trying to get, helping out 4 and 8, doing other things. But I was calling other rovers to come and be like, "Hey, I am not going to be able to hit the sight check, can you come hit it for me?" Chapel was full. There was a bunch of people, so not all the sight checks were done by me, and the logbooks reflect that.

Do you see that?

A I do.

Q And so that gets to the practices of the County you discussed earlier that different people can conduct the

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sight checks. Correct?
A Correct.
Q Okay. Now, you talked about -- and I forget exactly what you called it. The -- the -- the officer who is overseeing the whole floor, was that the "rover" --
A "Rover."
Q Just "rover"?
A Uh-huh.
Q There needs to be some type of exchange of information from the rover to the person coming on the next shift. Correct? If there's something to be talked about?
A Sure.
Q Is that -- is what Miles is talking about here, is that a -- was he the rover for that floor at that time?
A It sounds like he was. I don't think there's anything in there that said that he was. But based on what he's doing and having to bounce around and help other things, it sounds like he's the rover.
Q And so if he's the rover and if at that time he did have concerns about the health of Mr. Clinton, the County would expect some exchange of information from Miles to whoever is taking over, as you have described previously?
A Correct.
Q Is that true?

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A Correct.
Q Okay. I do want to go -- with the reporting issue in mind, I want to go to Peek asked Miles: "Did you ever go to your shift commander and say, 'Listen, this guy really needs help but medical is not -- they're not helping him?'
"Miles: No, I did not."
As you have described earlier on this upward reporting process, Miles would not be following that process. Correct? If he did not report that up the chain?
A Not necessarily, because he did report it to his corporal. So he could assume the corporal then reported it to the sergeant, and so on and so on.
Q Okay.
A I would -- me, I would encourage him at some point, if nothing is still getting done, then "overstep your corporal and go to your sergeant yourself" kind of thing.
Q And so, more specifically, who is Peek mentioning here when she says "shift commander"?
A That would be the lieutenant.
Q That would be the lieutenant?
A Correct.
Q Peek asked about Mr. Clinton asking for help in his cell and says:

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"Yes, like please help me. Was he doing that and no one would help him?
"Miles: He didn't say, 'Please help me,' but it was more like -- like a 'please, man, help me.'
"Peek: And then you just shut the door and went on?
"Miles: Pretty much. Yeah. Yes."
Do you believe that was an appropriate response at that point in time by Miles to the complaints being submitted by Mr. Clinton?
A I don't know what all Miles knew at the time. I think, prior to that, Miles is being told by the responsible medical authority that this individual is faking it. So I don't know Miles's mindset that, "okay, yeah, he's faking it, medical told me that," or is he at the stage of "I don't agree with this, I need to get more help." I -- I don't know.
Q Okay. But, again, you would agree with me that if Miles, if the officer in his position has doubts about what medical staff is saying, Miles does have a duty on his end to do something. Right?
A Pass that information on.
Q Okay.
MS. WILLIAMS: Geoff, may I have just one moment?

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(Sotto voce colloquy between Mr. Tabor and Ms. Williams)
Q (By Mr. Tabor) If in this case Miles had a suspicion something was really wrong with Mr. Clinton but the medical staff is saying, "Hey, he's faking it," would part of Miles's duties include going into the cell to interact with Mr. Clinton or investigate further?
A It could. That's a touchy, touchy subject there because you've got the "last locked door" standard. And lots of times, inmates have chose to fake something, even a suicide attempt, to get that officer to break that "last locked door," and then they have been attacked. So, again, I don't know what those circumstances were for Miles.
Q In this situation we're going over here, this back and forth between Jennifer Peek and Miles about observing Mr. Clinton, what medical staff was saying about Mr. Clinton, at what point in time, if ever, does the County expect its detention staff to call 911 for a medical emergency?
A Detention staff calls 911 at the direction of the contracted medical provider.
Q So there's no situation, ever, where the detention staff would call 911 on an inmate medical issue?
A Without medical being involved, I can't think of one. No.

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Q Would --
A Medical is always the go-to person.
Q Well, did the jail staff call 911 in Mr. Clinton's case, eventually?
A Eventually, I think, from the direction of Turnkey.
Q So to clarify here, there's just no situation that the detention staff on their own, without medical's involvement, calls 911. Correct?
A I mean, unless medical just is not available, which I can't imagine that's the case. I don't know of a situation, though.
Q And that would be the sheriff's office practice and expectation of its -- of its employees. Correct?
A It's back to that contract that that's your immediate medical response is that contracted medical provider.
Q We're still in Exhibit 27. I am going to go to page 17. Peek built a pretty detailed timeline of things, and I am not going to walk through everything with you. I am taking her deposition.
I had a quick question. I am finding it. What's the morpho window?
A That's where -- that's part of the book-in process. It's down in receiving on the first floor. It's

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where they actually take your electronic fingerprint, and it pulls up if you've ever been there, that kind of thing. Basically enters you into the system.
Q And then what is the medical waiting area?
A So at -- looking at dates.
At the time, the way it was designed in receiving was, after you went from morpho, you went to medical, because you had to be in the system for medical to be able to access you. You went back there. And we had designed two private areas where medical could meet with the intake, and adjacent to that was a little waiting area right in front of the nurses. So you're being observed while you're waiting.
Q So if someone's in the medical waiting area, the medical staff can see that inmate. Correct?
A Correct.
Q How long, typically, are people in the medical waiting area? Inmates? Detainees?
A I don't know. I would just be giving you a guess. I don't know.
Q What's -- do you have a number on kind of the usual custom?
A I think most nurses do an intake in about 15 minutes. So you're probably seeing somebody every 15 minutes.

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Q Do you know how long Mr. Clinton was in the medical waiting area?
A I do not.
Q Okay. Have you watched any of the security footage of when Mr. Clinton was brought into the waiting area?
A When he was admitted, no.
Q Are you aware he was left in his wheelchair with his pants down for over an hour?
A No.
Q Now that you know that, is that something that would be acceptable to the County if -- if a paralyzed detainee was left with his pants down for over an hour in that waiting area?
A No.
Q In terms of bringing an inmate into the medical waiting area and bringing him out, who typically does that?
A It's one of the intake officers.
Q One of the detention staff?
A It would be detention staff. Yeah.
Q Okay. The investigation report, at the bottom of page 17, Exhibit 27, mentions an orderly approaching Clinton in the medical waiting area.
What's your understanding of who that would be, how that term is used?

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A It's a trustee. And we don't use the word "trustee," but that's the most familiar term. It's an inmate from the second floor that's probably serving county jail time and is working as a trustee either to clean up or whatever. They've got a couple assigned to receiving, and they pretty much walk around and make sure, anybody that wants water, they've got water or those kind of things while they're cleaning up.
Q You have reviewed the investigation report from Peek and some of the other documents in this case. I know you haven't reviewed the security footage we were talking about a minute ago.
Do you know Mr. Clinton, in the cells that he was in, do you know how long he laid on his back without moving?
A No.
Q From the time that Mr. Clinton was brought into the jail to the time he was found on August the 10th, do you know how many individual detention staff interacted with him?
A Just the ones that were identified, that were interviewed by Deputy Peek.
Q Okay. Do you know how many people that is?
A I don't. I would have to go back there and count. Half a dozen, I think.

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Q Okay. In your review of the records in this case, the investigation report, is the County aware of any single detention staff observing Mr. Clinton being able to move his arms or legs during his time at the jail?

A I do believe that I had read somewhere where an officer said they saw him move his hands.

Q Hands?

A And then one described his arms being up by his head, like his arms had moved. I think that was it.

Q Would you agree with me that the County's not aware of any evidence indicating, while Mr. Clinton was at the jail, any of the detention staff calling 911. Correct?

A Correct.

Q That never happened. Is that true?

A Well, I believe Lieutenant Hendershott called 911 at the nursing gurney call.

Q At the end. Right?

A Yes. Yes.

Q All right. And did anybody -- other than Officer Miles contacting Mulanax, did any other detention staff contact their supervisors at any point in time?

A I believe -- I believe there was a sergeant that had contacted Lieutenant Carter, and then Lieutenant Carter got involved and did a movement -- I think she might have been the one that did the movement back to 13 Baker

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that didn't take place.

Q Officer Miles describes ultimately going into Mr. Clinton's cell. Correct?

A Correct.

Q And what's -- what's your understanding of why Officer Miles ultimately went into the cell? I know we talked about entering cells before and some of the concerns with that.

A Well, I know there was -- I don't know if this involved Miles. I know there was at one point where they had propped Mr. Clinton up. And it looked like he had slid down, and so somebody went in there. And at some point, they had noticed that he had defecated on himself. And I think that was Miles. And so that kind of exacerbated the contacting, after that point, of medical.

Q And does the County, sitting here today, know how long Mr. Clinton laid in his own feces in that cell?

A I don't believe so.

Q Mr. Clinton in his cell was showing signs that he was not able to feed himself. Correct?

A There -- I know there was statements of that. I also know officers said that he had a sack lunch, too. So they assumed he was eating the sack lunch and not the tray to perpetuate this -- what the nurses were saying: that he was faking it.

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Q But I believe Officer Miles noted that he had some doubts about whether Mr. Clinton was faking because he also was not eating. Correct?

A Well, I know he did reference, in the interview, that he had not ate his tray. He made notice of that. Because I think he even says that it's odd that somebody doesn't eat their tray in jail.

Q Do you think that all of the actions of the detention staff regarding Mr. Clinton were proper under the circumstances?

A I think so. I think they voiced concern. They tried to involve the appropriate people. And when nothing was getting done, they were continuing to voice concern and involve chain of command.

Q Do you think the actions of the Turnkey staff in regards to Mr. Clinton were appropriate?

A I can't speak to why they did what they did or why they thought he was faking. I am not a medical professional, and I don't know what reports they had got from Saint Anthony's and some of that kind of stuff. There's a question.

Q Now, I don't have the medical examiner's records here for your deposition, but it has the same cause of death. Deputy Peek's investigation notes the cause of death being blunt force trauma of cervical spine.

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Do you see that?

A I do.

Q Do you have any basis to doubt that determination?

A No.

Q And I will represent to you the Medical Examiner's Office made a similar finding on the cause of death. Would you have any basis to doubt the findings of the medical examiner?

A No.

Q I want to go back very briefly to the contract with Turnkey, Exhibit 3.

A Okay.

Q And I -- I am not going to go all the way through this again. I am not going to -- not going to replow that ground, but I just want to make sure we're clear on a few things.

This contract, since it was signed by Turnkey, the sheriff, and the County -- correct?

A Yes.

Q The expectation by the County and the sheriff was that detention staff would follow the terms and understandings of this contract with Turnkey. Right?

A Correct.

Q And under this contract, this written contract,

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the expectations were that detention staff at the jail were not to render medical care or make medical-related decisions. Correct?

A Opposite of basic First Aid and CPR, that would be correct.

MR. TABOR: Okay. Let's take a quick break.

(Short Recess from 12:33 p.m. to 12:36 p.m.)

Q (By Mr. Tabor) Just a few quick questions.

MR. HEGGY: Never say "quick." We know better.

MR. TABOR: Just a few questions.

Q (By Mr. Tabor) One of the topics in the notice is from January 1 -- from 2014 until the handover of the jail.

Were there -- during that time frame, were there any demands by Turnkey to the County or the sheriff's department for you-all to increase or improve your staffing?

A No. We -- we would meet sometimes biweekly, myself and the HSA. And we would always be talking about staffing -- theirs, ours, how we could better utilize. So lots of times, we were having conversations about, you know, changing staffing schedules because of, you know, doctors and all of them wanting to work business hours. So overstaffing on days for tasks, those kind of things. So that was a continuous conversation.

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I don't recall, either way, ever having a conversation that "you need to increase staffing" or "Turnkey needs to increase staffing."

MR. TABOR: Okay. I have no further questions at this time. I will pass the witness.

MR. HEGGY: He will read and sign.

(Deposition concluded at 12:38 p.m. and witness excused after 3 hours and 4 minutes on the record)

C E R T I F I C A T E

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, Lori Johnston Harstad, a Certified Shorthand Reporter for the State of Oklahoma, certify that Ernest Eugene "Gene" Bradley was by me sworn to testify the truth; that the deposition was taken by me in stenotype and thereafter transcribed by computer and is a true and correct transcript of the testimony of the witness; that the deposition was taken by me on February 28, 2023, at 9:08 a.m., at 320 Robert S. Kerr, Oklahoma City, Oklahoma; that I am not a relative, employee, attorney or counsel to any party in this case or a relative or employee to any counsel in this case or otherwise financially interested in this action; and that the witness elected to exercise his right to review the deposition transcript prior to its filing.

Witness my hand and seal of office on this 6th day of March, 2023.

Lori Johnston Harstad, CSR
Oklahoma Certified Shorthand Reporter
Certificate Number 1726
Expiration Date: December 31, 2023

Oklahoma CSR #01726
My Commission Expires 12/31/2022

JURAT

I, Ernest Eugene Bradley, do hereby state under oath that I have read the above and foregoing deposition in its entirety and that the same is a full, true, and correct transcription of my testimony so given at said time and place, except for the corrections noted.

_____ WITH CORRECTIONS

_____ WITHOUT CORRECTIONS

_____

Subscribed and sworn to before me, the undersigned Notary Public in and for the State of Oklahoma, on this, the _____ day of _____, 2023.

_____
NOTARY PUBLIC

My Commission Expires: _____

My Commission Number: _____

Reported by: Lori Johnston Harstad, CSR

ERRATA SHEET

WITNESS: Ernest Eugene Bradley, 30(b)(6)

CASE STYLE: Brothers v. Johnson, et al.

REPORTER: Lori Johnston Harstad, CSR

PAGE	LINE	CORRECTION AND REASON